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CHALENG 2005 Survey: VA Boston HCS (VAMC Boston - 523 and VAMC W. Roxbury - 523A4), VAMC Brockton, MA - 523A5 and VAH Bedford, MA

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 1500

2. Estimated Number of Veterans who are Chronically Homeless: 270

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 1500 (estimated number of homeless veterans in service area) **x chronically homeless rate (18 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	600	5
Transitional Housing Beds	828	50
Permanent Housing Beds	35	750

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 22

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	We hope to use tax credits to develop new housing along with the mayor's tax on the sale of property.
Drop-in center or day program	We are discussing the need for a drop-in center where dually diagnosed individuals can get their social needs met. We hope to expand the existing drop-in center at the VA Medical Center.
Dental care	We will seek to obtain a memorandum of understanding with Tufts and BU Schools of Dentistry to expand services to homeless veterans.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **55** **Non-VA staff Participants: 52.8%**
Homeless/Formerly Homeless: **9.1%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.59	.0%	3.47
Food	3.92	2.0%	3.80
Clothing	3.69	2.0%	3.61
Emergency (immediate) shelter	3.68	20.0%	3.33
Halfway house or transitional living facility	3.39	2.0%	3.07
Long-term, permanent housing	2.34	53.0%	2.49
Detoxification from substances	3.23	2.0%	3.41
Treatment for substance abuse	3.48	11.0%	3.55
Services for emotional or psychiatric problems	3.6	16.0%	3.46
Treatment for dual diagnosis	3.4	16.0%	3.30
Family counseling	2.88	11.0%	2.99
Medical services	3.92	16.0%	3.78
Women's health care	2.98	13.0%	3.23
Help with medication	3.14	.0%	3.46
Drop-in center or day program	3.17	.0%	2.98
AIDS/HIV testing/counseling	3.02	2.0%	3.51
TB testing	3.38	4.0%	3.71
TB treatment	3.37	.0%	3.57
Hepatitis C testing	3.57	.0%	3.63
Dental care	2.58	4.0%	2.59
Eye care	3.02	2.0%	2.88
Glasses	3.09	.0%	2.88
VA disability/pension	3.59	7.0%	3.40
Welfare payments	3.06	.0%	3.03
SSI/SSD process	3.55	2.0%	3.10
Guardianship (financial)	3.14	4.0%	2.85
Help managing money	3.15	4.0%	2.87
Job training	3.17	20.0%	3.02
Help with finding a job or getting employment	3.15	16.0%	3.14
Help getting needed documents or identification	3.42	.0%	3.28
Help with transportation	2.72	16.0%	3.02
Education	3.14	13.0%	3.00
Child care	2.15	7.0%	2.45
Legal assistance	2.55	9.0%	2.71
Discharge upgrade	2.77	.0%	3.00
Spiritual	3.02	.0%	3.36
Re-entry services for incarcerated veterans	2.67	16.0%	2.72
Elder Healthcare	2.98	7.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.80
Co-location of Services - Services from the VA and your agency provided in one location.	2.48
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.58
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.83
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.04
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.33
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.60
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.72
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.33
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.13
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.21
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.92

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.46
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.63

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CHALENG 2005 Survey: VA Connecticut HCS (VAMC Newington and VAMC West Haven)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 4675

2. Estimated Number of Veterans who are Chronically Homeless: 1590

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 4675 (estimated number of homeless veterans in service area) **x chronically homeless rate (34 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	1882	220
Transitional Housing Beds	996	375
Permanent Housing Beds	20	2800

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 15

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue to work with Partnership for Strong Communities in their "Reaching Home" campaign. Continue participation on Connecticut coalition to end homelessness advocacy committee.
Transportation	Discuss CHALENG survey results with community partners and with VA transportation services. Educate community partners about extensive, existing campus shuttle and state Department of Veterans Affairs shuttle schedules. Work to identify and address gap
Immediate shelter	Discuss this CHALENG survey result with Connecticut coalition to end homelessness. Support efforts to increase number of beds during cold weather.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **47 Non-VA staff Participants: 69.6%**
Homeless/Formerly Homeless: **31.9%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	2.84	3.0%	3.47
Food	3.23	16.0%	3.80
Clothing	2.84	3.0%	3.61
Emergency (immediate) shelter	2.87	32.0%	3.33
Halfway house or transitional living facility	2.82	8.0%	3.07
Long-term, permanent housing	2.40	62.0%	2.49
Detoxification from substances	3.26	3.0%	3.41
Treatment for substance abuse	3.23	11.0%	3.55
Services for emotional or psychiatric problems	3.4	11.0%	3.46
Treatment for dual diagnosis	3.2	8.0%	3.30
Family counseling	2.88	.0%	2.99
Medical services	3.47	8.0%	3.78
Women's health care	2.47	11.0%	3.23
Help with medication	3.12	5.0%	3.46
Drop-in center or day program	2.85	8.0%	2.98
AIDS/HIV testing/counseling	3.12	.0%	3.51
TB testing	3.26	.0%	3.71
TB treatment	3.21	.0%	3.57
Hepatitis C testing	3.40	.0%	3.63
Dental care	2.36	13.0%	2.59
Eye care	3.00	3.0%	2.88
Glasses	2.98	5.0%	2.88
VA disability/pension	3.23	10.0%	3.40
Welfare payments	2.39	3.0%	3.03
SSI/SSD process	2.87	3.0%	3.10
Guardianship (financial)	2.58	.0%	2.85
Help managing money	2.50	5.0%	2.87
Job training	2.70	11.0%	3.02
Help with finding a job or getting employment	2.77	16.0%	3.14
Help getting needed documents or identification	3.40	.0%	3.28
Help with transportation	2.60	36.0%	3.02
Education	2.90	5.0%	3.00
Child care	2.08	.0%	2.45
Legal assistance	2.60	.0%	2.71
Discharge upgrade	3.13	5.0%	3.00
Spiritual	2.79	.0%	3.36
Re-entry services for incarcerated veterans	2.81	3.0%	2.72
Elder Healthcare	2.84	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.67
Co-location of Services - Services from the VA and your agency provided in one location.	2.26
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.24
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.80
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.50
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.80
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.50
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.12
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.83
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.65
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.96

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.58
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.61

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CHALENG 2005 Survey: VAM&ROC Togus, ME - 402

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 120

2. Estimated Number of Veterans who are Chronically Homeless: 13

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 120 (estimated number of homeless veterans in service area) **x chronically homeless rate (11 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	400	0
Transitional Housing Beds	18	0
Permanent Housing Beds	5	7

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility or halfway house	Continue to develop formal agreements via VA Grant and Per Diem contract awards with Volunteers of America (VOA) and Maine Department of Labor for 10 transitional housing beds and 8 permanent housing beds.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **6** **Non-VA staff Participants: .0%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.50	.0%	3.47
Food	4.25	.0%	3.80
Clothing	4.25	.0%	3.61
Emergency (immediate) shelter	3.75	.0%	3.33
Halfway house or transitional living facility	3.00	100.0%	3.07
Long-term, permanent housing	3.25	75.0%	2.49
Detoxification from substances	3.25	.0%	3.41
Treatment for substance abuse	3.50	.0%	3.55
Services for emotional or psychiatric problems	4.0	.0%	3.46
Treatment for dual diagnosis	2.8	25.0%	3.30
Family counseling	3.75	.0%	2.99
Medical services	4.25	25.0%	3.78
Women's health care	4.00	.0%	3.23
Help with medication	3.25	25.0%	3.46
Drop-in center or day program	3.00	25.0%	2.98
AIDS/HIV testing/counseling	4.25	.0%	3.51
TB testing	4.25	.0%	3.71
TB treatment	3.75	.0%	3.57
Hepatitis C testing	4.25	.0%	3.63
Dental care	2.75	.0%	2.59
Eye care	2.75	.0%	2.88
Glasses	3.50	.0%	2.88
VA disability/pension	4.50	.0%	3.40
Welfare payments	4.50	.0%	3.03
SSI/SSD process	4.25	.0%	3.10
Guardianship (financial)	4.25	.0%	2.85
Help managing money	3.00	25.0%	2.87
Job training	3.75	.0%	3.02
Help with finding a job or getting employment	4.00	.0%	3.14
Help getting needed documents or identification	4.00	.0%	3.28
Help with transportation	3.00	.0%	3.02
Education	3.00	.0%	3.00
Child care	2.50	.0%	2.45
Legal assistance	2.50	.0%	2.71
Discharge upgrade	3.75	.0%	3.00
Spiritual	3.25	.0%	3.36
Re-entry services for incarcerated veterans	2.50	.0%	2.72
Elder Healthcare	3.00	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	
Co-location of Services - Services from the VA and your agency provided in one location.	
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	

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CHALENG 2005 Survey: VAM&ROC White River Junction, VT - 405

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 20

2. Estimated Number of Veterans who are Chronically Homeless: 2

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 20 (estimated number of homeless veterans in service area) **x chronically homeless rate (11 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	30	0
Transitional Housing Beds	26	0
Permanent Housing Beds	0	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 1

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Open 16-unit apartment complex in Rutland, Vermont for veterans.
Treatment for substance abuse	Expand substance abuse treatment at VA.
Job training	Expand CWT throughout state of Vermont and expand CWT Department at VAM/ROC WRJ.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **16** **Non-VA staff Participants: 100.0%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	2.47	7.0%	3.47
Food	3.20	7.0%	3.80
Clothing	2.80	7.0%	3.61
Emergency (immediate) shelter	2.38	57.0%	3.33
Halfway house or transitional living facility	1.53	67.0%	3.07
Long-term, permanent housing	1.71	53.0%	2.49
Detoxification from substances	2.47	.0%	3.41
Treatment for substance abuse	2.50	14.0%	3.55
Services for emotional or psychiatric problems	2.5	29.0%	3.46
Treatment for dual diagnosis	2.3	21.0%	3.30
Family counseling	2.60	.0%	2.99
Medical services	2.87	7.0%	3.78
Women's health care	2.67	7.0%	3.23
Help with medication	2.38	.0%	3.46
Drop-in center or day program	1.93	7.0%	2.98
AIDS/HIV testing/counseling	2.71	.0%	3.51
TB testing	2.60	.0%	3.71
TB treatment	2.50	.0%	3.57
Hepatitis C testing	2.87	.0%	3.63
Dental care	1.87	7.0%	2.59
Eye care	2.06	.0%	2.88
Glasses	2.13	.0%	2.88
VA disability/pension	2.50	.0%	3.40
Welfare payments	2.87	.0%	3.03
SSI/SSD process	2.50	.0%	3.10
Guardianship (financial)	2.00	.0%	2.85
Help managing money	2.19	.0%	2.87
Job training	2.47	.0%	3.02
Help with finding a job or getting employment	2.50	.0%	3.14
Help getting needed documents or identification	2.87	.0%	3.28
Help with transportation	2.73	7.0%	3.02
Education	2.60	.0%	3.00
Child care	1.93	.0%	2.45
Legal assistance	1.94	.0%	2.71
Discharge upgrade	2.13	.0%	3.00
Spiritual	2.62	.0%	3.36
Re-entry services for incarcerated veterans	2.13	.0%	2.72
Elder Healthcare	2.54	7.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	1.80
Co-location of Services - Services from the VA and your agency provided in one location.	1.20
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.63
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.25
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.06
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.19
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.13
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.56
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.13
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.40
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.13
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.50

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	2.60
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	2.53

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Manchester, NH - 608

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 350

2. Estimated Number of Veterans who are Chronically Homeless: 63

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 350 (estimated number of homeless veterans in service area) **x chronically homeless rate (18 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	580	0
Transitional Housing Beds	480	10
Permanent Housing Beds	5	350

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 2

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	State of New Hampshire still in housing crisis for affordable units. Ten-year Plan to End Homelessness initiating more political attention.
Transportation	Transportation difficult as transitional housing not always near public transportation. DAV, VA and local transportation does help some veterans get to appointments, jobs, etc.
Treatment for dual diagnosis	Non-VA facility available locally, but nearest VA dual diagnosis program is 45 miles south in Massachusetts. Will continue to help educate local housing providers on needs and expectations of dually diagnosed veterans.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **18** **Non-VA staff Participants: 100.0%**
Homeless/Formerly Homeless: **5.6%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.06	7.0%	3.47
Food	3.53	.0%	3.80
Clothing	3.41	.0%	3.61
Emergency (immediate) shelter	3.12	20.0%	3.33
Halfway house or transitional living facility	3.24	20.0%	3.07
Long-term, permanent housing	2.44	73.0%	2.49
Detoxification from substances	2.76	27.0%	3.41
Treatment for substance abuse	2.67	27.0%	3.55
Services for emotional or psychiatric problems	2.8	7.0%	3.46
Treatment for dual diagnosis	2.7	13.0%	3.30
Family counseling	3.19	7.0%	2.99
Medical services	3.65	7.0%	3.78
Women's health care	3.60	.0%	3.23
Help with medication	3.73	7.0%	3.46
Drop-in center or day program	2.69	13.0%	2.98
AIDS/HIV testing/counseling	3.53	.0%	3.51
TB testing	3.57	.0%	3.71
TB treatment	3.23	.0%	3.57
Hepatitis C testing	3.64	.0%	3.63
Dental care	2.93	7.0%	2.59
Eye care	2.93	7.0%	2.88
Glasses	2.86	.0%	2.88
VA disability/pension	3.33	.0%	3.40
Welfare payments	3.00	.0%	3.03
SSI/SSD process	3.25	.0%	3.10
Guardianship (financial)	2.67	.0%	2.85
Help managing money	2.65	.0%	2.87
Job training	3.00	13.0%	3.02
Help with finding a job or getting employment	3.13	7.0%	3.14
Help getting needed documents or identification	3.00	7.0%	3.28
Help with transportation	2.47	20.0%	3.02
Education	2.94	.0%	3.00
Child care	2.27	.0%	2.45
Legal assistance	2.75	.0%	2.71
Discharge upgrade	2.75	.0%	3.00
Spiritual	3.43	.0%	3.36
Re-entry services for incarcerated veterans	2.29	7.0%	2.72
Elder Healthcare	3.07	7.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.29
Co-location of Services - Services from the VA and your agency provided in one location.	1.36
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.54
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.43
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.43
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.36
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.57
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.14
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.86
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.69
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.54
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.93

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.24
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.71

Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2005 Survey: VAMC Northampton, MA - 631 (Leeds)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 180

2. Estimated Number of Veterans who are Chronically Homeless: 68

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 180 (estimated number of homeless veterans in service area) **x chronically homeless rate (38 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	190	0
Transitional Housing Beds	145	10
Permanent Housing Beds	70	30

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Treatment for substance abuse	Work with community providers to assess need for substance abuse treatment for veterans in community.
Long-term, permanent housing	Work with community providers to inventory available housing. Attend Continuum of Care meetings in community, including the Mayor of Northampton's committee on homelessness.
Transitional living facility or halfway house	Work with community providers to compile an up-to-date listing of all transitional housing in community.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **66** **Non-VA staff Participants: 81.4%**
Homeless/Formerly Homeless: **12.1%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.68	2.0%	3.47
Food	4.03	4.0%	3.80
Clothing	3.78	.0%	3.61
Emergency (immediate) shelter	3.59	16.0%	3.33
Halfway house or transitional living facility	3.39	24.0%	3.07
Long-term, permanent housing	2.87	54.0%	2.49
Detoxification from substances	3.62	16.0%	3.41
Treatment for substance abuse	3.75	29.0%	3.55
Services for emotional or psychiatric problems	3.7	17.0%	3.46
Treatment for dual diagnosis	3.5	22.0%	3.30
Family counseling	3.09	4.0%	2.99
Medical services	3.84	8.0%	3.78
Women's health care	3.47	.0%	3.23
Help with medication	3.67	4.0%	3.46
Drop-in center or day program	3.38	14.0%	2.98
AIDS/HIV testing/counseling	3.59	.0%	3.51
TB testing	3.87	.0%	3.71
TB treatment	3.72	.0%	3.57
Hepatitis C testing	3.83	.0%	3.63
Dental care	3.22	6.0%	2.59
Eye care	3.23	2.0%	2.88
Glasses	3.12	4.0%	2.88
VA disability/pension	3.44	8.0%	3.40
Welfare payments	3.32	.0%	3.03
SSI/SSD process	3.34	.0%	3.10
Guardianship (financial)	2.84	4.0%	2.85
Help managing money	2.88	8.0%	2.87
Job training	3.14	18.0%	3.02
Help with finding a job or getting employment	3.18	18.0%	3.14
Help getting needed documents or identification	3.40	2.0%	3.28
Help with transportation	3.37	10.0%	3.02
Education	3.29	6.0%	3.00
Child care	2.54	2.0%	2.45
Legal assistance	3.02	2.0%	2.71
Discharge upgrade	3.00	.0%	3.00
Spiritual	3.31	.0%	3.36
Re-entry services for incarcerated veterans	2.96	2.0%	2.72
Elder Healthcare	3.39	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.24
Co-location of Services - Services from the VA and your agency provided in one location.	1.63
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.68
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.98
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.39
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.64
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.91
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.11
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.71
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.67
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.74
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.02

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.85
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.65

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Providence, RI - 650, Bristol, CT

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 175

2. Estimated Number of Veterans who are Chronically Homeless: 23

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 175 (estimated number of homeless veterans in service area) **x chronically homeless rate (13 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	2	10
Transitional Housing Beds	57	10
Permanent Housing Beds	6	20

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue to meet with community agencies and federal grant programs to explore permanent housing options for our veterans.
Transitional living facility or halfway house	Assist Northern Rhode Island Community Services in expansion of Grant and Per Diem beds throughout the state. NRI recent was awarded $144,000 from VA Grant and Per Diem for five beds.
Immediate shelter	Rhode Island Operation Stand Down would like to open a "Veterans Only" shelter in Rhode Island. Will offer support.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **24** **Non-VA staff Participants: 75.0%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.33	.0%	3.47
Food	3.79	4.0%	3.80
Clothing	3.50	4.0%	3.61
Emergency (immediate) shelter	3.13	38.0%	3.33
Halfway house or transitional living facility	2.92	38.0%	3.07
Long-term, permanent housing	2.08	79.0%	2.49
Detoxification from substances	3.92	.0%	3.41
Treatment for substance abuse	3.67	13.0%	3.55
Services for emotional or psychiatric problems	3.8	.0%	3.46
Treatment for dual diagnosis	3.7	8.0%	3.30
Family counseling	3.08	13.0%	2.99
Medical services	3.58	13.0%	3.78
Women's health care	3.25	4.0%	3.23
Help with medication	3.00	4.0%	3.46
Drop-in center or day program	2.42	13.0%	2.98
AIDS/HIV testing/counseling	3.79	.0%	3.51
TB testing	4.13	.0%	3.71
TB treatment	4.00	.0%	3.57
Hepatitis C testing	4.00	.0%	3.63
Dental care	2.29	4.0%	2.59
Eye care	2.54	8.0%	2.88
Glasses	2.54	.0%	2.88
VA disability/pension	3.50	13.0%	3.40
Welfare payments	2.83	4.0%	3.03
SSI/SSD process	3.21	.0%	3.10
Guardianship (financial)	2.63	.0%	2.85
Help managing money	3.04	.0%	2.87
Job training	3.08	4.0%	3.02
Help with finding a job or getting employment	3.17	17.0%	3.14
Help getting needed documents or identification	3.25	4.0%	3.28
Help with transportation	2.67	.0%	3.02
Education	2.75	.0%	3.00
Child care	2.04	4.0%	2.45
Legal assistance	2.79	4.0%	2.71
Discharge upgrade	2.83	.0%	3.00
Spiritual	2.96	.0%	3.36
Re-entry services for incarcerated veterans	2.54	8.0%	2.72
Elder Healthcare	3.38	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.89
Co-location of Services - Services from the VA and your agency provided in one location.	2.78
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.83
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.44
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.56
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.83
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.67
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.67
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.33
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.50
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.56
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.94

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.22
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.17